



APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE NURSING AND MIDWIFERY TECHNICIAN EXAMINATION

INSTRUCTIONS:

Number 1 to 12 to be completed by candidates

Numbers A to C to be completed by the person in charge of the programme

OFFICE USE

FEE.....
ELIGIBLE.....
EXAM NUMBER.....
EXAM RESULTS.....
MK.....

1. ENCLOSED EXAMINATION FEE.....

2. DATES OF EXAMINATION.....

3. SURNAME.....FIRST NAME.....

MAIDEN NAME (If Married).....

4. INDEX NUMBER.....NATIONAL ID NUMBER.....

5. DATE PROGRAMME COMMENCED.....

6. PERMANENT HOME ADDRESS:

VILLAGE.....

T/A.....

DISTRICT.....

7. CONTACT ADDRESS.....

.....

PHONE NUMBER.....

EMAIL ADDRESS.....

8. NAME OF

UNIVERSITY/COLLEGE.....

9. REGION AT WHICH EXAMINATION WILL BE TAKEN

NORTH CENTRAL SOUTH

10. PLEASE TICK EXAMINATION BEING APPLIED FOR:

FIRST ADMISSION RE-ADMISSION

11. IF READMISSION INDICATE THE NUMBER OF ATTEMPT

SECOND ATTEMPT THIRD ATTEMPT

FOURTH ATTEMPT OTHER (PLEASE SPECIFY)

12. IF IT IS NOT THE FIRST ATTEMPT INDICATE THE SPECIFIC EXAMINATION PAPER/S APPLYING

NURSING PAPER ONE NURSING PAPER TWO
MIDWIFERY PAPER ONE MIDWIFERY PAPER TWO

SIGNATURE OF STUDENT:.....DATE:.....

I certify that this form is being submitted subject to the following conditions:

- a. The candidate has completed the required theoretical instructions and clinical experiences.
- b. The candidate has passed the theoretical examination conducted by the school.
- c. The candidate has attained satisfactory performance in clinical nursing.

NAME OF PERSON IN-CHARGE OF PROGRAMME:.....

SIGNATURE.....DATE.....



Return the form to:

The Registrar
Nurses and Midwives Council of
Malawi
P.O. Box 30361
LILONGWE 3



APPLICATION FOR REGISTRATION

I hereby make application for my name to be enrolled on the roll of Nursing and Midwifery Technician maintained by the Nurses and Midwives Council of Malawi

<u>FOR OFFICIAL USE</u>
FEE PAID MK.....
RECIPT NUMBER.....

Indicate with a the register which this application is made

Nursing Midwifery Technician (NMT)

STATE CLEARLY

TYPE OF TRAINING	NAME OF EDUCATIONAL INSTITUTION AND ADDRESS	DATE TRAINING		CERTIFICATE NUMBER (if applicable)
		COMMENCED	COMPLETED	

Enclosed initial Registration fee MK.....Receipt No.....

Student Index Number.....National ID Number.....

Surname.....First Name.....

Other Names.....Maiden Name (if
Married).....Date of Birth...../...../.....

Permanent Home address:
Village.....T/A.....District.....

Nationality.....

Signature of applicant.....Date...../...../.....

Name of Head of Institution or designate.....

Signature.....Date...../...../.....



Return the form to The Registrar
 Nurses and Midwives Council of Malawi
 P.O. Box 30361
 LILONGWE 3



SUMMARY OF THE NURSING AND MIDWIFERY TECHNICIANS' CLINICAL EXPERIENCE

INSTRUCTIONS:

This form must be completed and signed by the Principal or his/her designate of the training institution where the candidate pursued the course.

Name of Institution.....

Address.....

I certify that

SURNAME

FIRST NAME

Was indexed by the Nurses and Midwives Council on...../...../.....

Date Course Commenced...../...../.....Date course completed...../...../.....

SUMMARY OF CLINICAL EXPERIENCE ACQUIRED BY THE CANDIDATE

Clinical Area	Prescribed Hours	Hours Completed
Basic Nursing	240	
Medical Ward	240	
TB ward	80	
Outpatient and Casualty Nursing	80	
Operating Theatre	160	
ICU/HDU	80	
Surgical ward /Gynaecology	240	
Paediatric Ward	280	
Mental Health and Psychiatric Nursing	160	
STI clinic	40	
ART (Paediatric and Adult ART)	120	
Under five clinic	160	
Nutrition Clinic	40	
Community Diagnosis	40	
Home Visit	40	
School Health	40	
Occupational Health	40	
Family Planning	160	
Antenatal Clinic	160	
Antenatal Ward	120	
Labour Ward	400	
Postnatal Clinic	40	
Postnatal Ward	240	
Health Centre Management	120	
Neonatal Ward	160	
TOTAL	3480	

N.B. Please indicate clearly where clinical experiences were combined.

RESULTS OF ASSESSMENT

	ASSESSMENT TITLE	NO.OF ENTRIES	RESULTS	COMMENT
1	Basic Nursing Care			
2	Care of a pre and post operative patient			
3	Care of the Under-five child (well child)			
4	Care of a Mentally ill patient			
5	Care of a client seeking Family Planning			
6	Care of the Antenatal Woman			
7	Care of a Woman in Labour			
8	Care of a Postnatal Woman within the first 48 hours			
9	Care of a Neonate within the first 48 hours			

OTHER MIDWIFERY REQUIREMENTS

	Procedure	No. Required	No. of cases Done
1	Complete Assessment of pregnant women at first antenatal visit	10	
2	Complete assessment of pregnant women on subsequent visit	40	
3	Vaginal examinations including pelvic assessment	20	

	Procedure	No. Required	No. of cases Done
4	Conduct spontaneous deliveries under minimum supervision	20	
5	Examination of placenta and membranes for completeness and abnormalities	10	
6	Performing and repairing episiotomies using local anaesthesia	2	
7	Repairing perineal tears/ lacerations using local anaesthesia	3	
8	Conducting Breech delivery	1	
9	Conducting multiple delivery	1	
10	Care of postnatal mothers and their babies	20	
11	Counsel mothers for HIV testing	10	
12	Providing PMTCT prophylactic drugs to infants	5	
13	Conducting postnatal assessments of mothers and infants at one week	10	
14	Conducting postnatal assessments of mothers and infants at 6 th week	2	
15	Resuscitate babies with Asphyxia	5	
16	Observe Manual removal of placenta	1	
17	Conducting Bi-manual compression	1	

	Procedure	No. Required	No. of cases Done
18	Observe vacuum Extractions	3	
19			
20			

Signature of Principal/ Designate:.....Date:...../...../.....

